Priority: Prevent Chronic Diseases					
Focus Area 1: Reduce Obesity in Children and Adults					
Timeframe: To be completed by December 31, 2018 (Ongoing)					
Do the suggested intervention(s) address a disparity? ☒ Yes ☐ No *Objective 1.4.2 – Lower socioeconomic status (SES) female employees at county located worksites.					
Goal	**Outcome Objectives**	**Interventions/Strategies / Activities**	**Process Measures**	**Partner Role**	**Partner Resources**
#1.4 Expand the role of public and private employers in obesity prevention	**Objective 1.4.2:** By 12/31/18 increase the percentage of employers with supports for breastfeeding at the worksite by 10%.	Use the Business Case for Breastfeeding to encourage employers to implement breastfeeding-friendly policies.	* Number of employers that have implemented lactation support programs * Number and demographics of women reached by policies & practices to support breastfeeding.	Finger Lakes Health (FLH) to provide Business Case for Breastfeeding and CLC referral materials to practices who see new mothers. LHD to actively participate in the Finger Lakes Breastfeeding Partnership (FLBP). LHD will identify worksites employing women and will prioritize those likely employing women of lower SES. LHD will outreach to a minimum of 2 worksites per year and will offer training, resource materials, & assistance to facilitate the implementation of policies. LHD will maintain 1 staff with current Certified Lactation Counselor (CLC) status who can provide technical expertise to employers and their workforce. FLBP, Regional Worksite Wellness Committee, and S2AY Rural Health Network (RHN) to support efforts of LHD and FLH.	FLH: 0.01 FTE to support efforts. LHD Resources: Full Time Maternal Child Health/CLC Nurse devoting approximately 0.25FTE to Breastfeeding initiatives. FLBP/Regional Worksite Wellness Committee/S2AY RHN: $3,300 (2 years)

Priority: Prevent Chronic Diseases					
Focus Area 3: Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings					
Timeframe: To be completed by December 31, 2018 (Ongoing)					
Do the suggested intervention(s) address a disparity? ☒ Yes ☐ No *Objective 3.2.4 – Lower SES patients receiving primary care through the Federally Qualified Health Center (FQHC). *Objective 3.3.1 – Clients of Workforce Development Job Club are un or under employed individuals with a higher percentage being lower SES and male.					
Goal	**Outcome Objectives**	**Interventions/Strategies /Activities**	**Process Measures**	**Partner Role**	**Partner Resources**
#3.2 Promote evidence-based care to manage chronic diseases.	**Objective 3.2.4:** By 12/31/18 increase the percentage of health plan members, ages 18-85 years, with hypertension who have controlled their blood pressure (below 140/90).	Promote the use of evidence-based interventions (EBIs) to prevent or manage chronic diseases, including the use of decision support tools/reminder systems in EMRs. Promote provider practice participation in the regional blood pressure registry. Promote participation of FQHCs in the Health Systems Learning Collaborative (HSLC) efforts. Offer technical assistance & quality improvement training to providers.	*Number of primary care practices that submit patient numbers to the regional registry. *Number of follow-up contacts made with participating providers following biannual practice level registry reports. *Percentage of patients in the participating FQHC diagnosed with HTN that are controlled. *Percentage of patients in the participating FQHC diagnosed with HTN that have been screened for pre diabetes and diabetes.	FLH provider offices to provide data to the registry & "My Reminder Campaign" materials to patients, as needed. LHD to actively participate in the HSLC and offer training/assistance with quality improvement/practice change to FQHCs and provider practices. Other Partners include: Finger Lakes Health Systems Agency (FLHSA), CHY (Choose Health Yates) Coalition, S2AY RHN, Finger Lakes Community Health (FLCH)/Penn Yan Community Health (PYCH), and HCCNY. The FLHSA will administer Hypertension (HTN) Registry Program including technical assistance, data & report compilation and outreach to provider practices. FLCH/PYCH will provide data to the HTN registry 2x/year & will continue to participate in the HSLC. CHY Coalition and S2AY RHN will promote & support the program.	FLH: 0.02 FTE LHD: Full time Chronic Disease Nurse and full time Health Educator. Each devoting approximately 0.25 FTE to chronic disease initiatives. FLHSA: In kind support S2AY RHN: $2,475 (2 years)
#3.3 Promote culturally relevant chronic disease	**Objective 3.3.1:** By 12/31/18 increase by at least 5% the percentage of adults with arthritis,	Promote the use of evidence-based interventions to prevent or manage chronic	*Number & type of evidence-based self-management programs offered by partners.	FLH to provide care managers in physician practices with information to facilitate referral into Chronic Disease Self-Management programs (CSDMP).	FLH: 0.01 FTE LHD: Full time Chronic Disease

self-management education.	asthma, cardiovascular disease, or diabetes who have taken a course or class to learn how to manage their condition.	diseases, including the use of decision support tools/reminder systems in EHRs.	* Number of participants at EBIs offered by partners. * Number of providers that use EHRs to trigger patient education/referrals. * Number of referrals to EBIs made by providers. * Percent of adults with one or more chronic diseases who have attended a self-management program.	LHD will promote and offer the National Diabetes Prevention Program (NDPP). LHD will explore opportunities with Workforce Development Office to offer NDPP or CDSMP to their clients. LHD will promote & assist with referral to CDSMP. LHD will encourage provider practice use of EHRs support tools. Other partners include: ProAction Office for the Aging & PYCH which provide CDSMP classes. S2AY RHN and Living Healthy group to assist in coordination of classes and provide extra peer leaders for classes. CHY Coalition will provide support & promote programs.	Nurse and Full time Health Educator, each devoting approximately 0.25 FTE to chronic disease initiatives. S2AY RHN/ Living Healthy group: $1,886 (2 years)

Priority: Promote Mental Health and Prevent Substance Abuse					
Focus Area 1: Promote Mental, Emotional and Behavioral Well-Being					
Timeframe: To be completed by December 31, 2018 (Ongoing)					
Do the suggested intervention(s) address a disparity? ☐ Yes ☒ No					
Goal	**Outcome Objectives**	**Interventions/Strategies/Activities**	**Process Measures**	**Partner Role**	**Partner Resources**
#1.1 Promote mental, emotional and behavioral well-being in communities.	**Objective 1.1.1:** Increase the use of evidence-informed policies & evidence-based programs that are grounded on healthy development of children, youth & adults.	Offer and promote the Mental Health First Aid and Youth Mental Health First Aid program to community members, schools and worksites. Offer and promote QPR	* Number of Mental Health First Aid & Youth Mental Health First Aid trainings offered. * Number of QPR Gatekeeper trainings offered.	FLH to support trainings through promotion to employees and participation in Yates Substance Abuse and Suicide Prevention Coalitions. LHD to actively participate in the Yates County Substance Abuse Coalition (YSAC) and the Yates County Suicide Coalition. LHD will encourage county workforce attendance at EBI training programs and will promote training opportunities	FLH: 0.01 FTE LHD: LHD Director serves on the YSAC Steering Committee and the Suicide

		Gatekeeper Training opportunities to community members.	* Number of individuals that have attended trainings.	for members of the public & professionals via website, social media and media releases. Other partners include: Community Services, YSAC, Suicide Coalition, and CHY Coalition. Community Services provides training at no cost to attendees. The Coalitions assist by promoting the training opportunities.	Coalition, each meeting monthly. Public Health Educator serves on YSAC and the Community Education Subcommittee, each meeting monthly.
#2.1 Prevent underage drinking, non-medical use of prescription pain relievers by youth, & excessive alcohol consumption by adults.	**Objective 2.1.1:** Reduce the percentage of youth in grades 9-12 reporting the use of alcohol on at least one day for the past 30 days to no more than 34.6% Reduce the percentage of youth indicating substance use on the Yates County youth survey.	Too Good for Drugs program offered in the Dundee & Penn Yan School districts for the 2016-2017 school year.	* Number of program sessions offered. * Number of youth participating in each school district. * Data and review from youth survey.	FLH to support through creating awareness of programs to employees and providers; representation on YSAC, and Narcan training for employees. LHD to participate in review/analysis of Youth Survey data, support awareness campaigns, serve on YSAC and operate OOP Program. Other partners include: Community Services which administers and pays for the biannual youth survey, local school districts, Council on Alcoholism & Addictions of the Finger Lakes which conduct the program, YSAC which covers the cost of student materials for the program	FLH: 0.01 FTE LHD: LHD Director serves on the YSAC Steering Committee and the Suicide Coalition, each meeting monthly. Public Health Educator serves on YSAC and the Community Education Subcommittee, each meeting monthly. SPHN conducts Narcan training events.